



Kelley Counseling
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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ (client/guardian), hereby authorize the release and exchange of information specified below between **Kelley Counseling** and:

Name of person/organization information is to be released (address, phone & fax if available):

Client Name: _____ DOB: _____

Purpose of the disclosure authorized (as specific as possible)

Coordination of Care Referral Payment Utilization Management Other

Data may be released in written, verbal, or electronic form and may include copies of the following information:

(Please check all applicable information, enter NA if not requested)

<input type="checkbox"/> Psychiatric Evaluation	<input type="checkbox"/> Psychological/Educational Testing
<input type="checkbox"/> General Progress in Treatment	<input type="checkbox"/> Alcohol or Substance Abuse History and TX
<input type="checkbox"/> HIV/AIDS History and TX	<input type="checkbox"/> Medication History/Physician Orders
<input type="checkbox"/> Service Plan/PCP	<input type="checkbox"/> Labs and Special Tests as Indicated
<input type="checkbox"/> Discharge/Transfer Summary	<input type="checkbox"/> Continuing Care Plan
<input type="checkbox"/> Collection of Fees/Payment	<input type="checkbox"/> Diagnosis
<input type="checkbox"/> Presence/Participation in TX	<input type="checkbox"/> Other: _____

This Authorization For Release Of Information has been explained to me and I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this authorization is voluntary, and I have the right to have this Release reviewed by a third party or independent counsel. Further, I understand that this consent shall expire twelve (12) months from the date below and must be reauthorized at that time. I understand that I have the right to revoke this authorization at any time by sending written notice to Amelia Kelley.

Signature of Client

Date

Signature of Parent/Legal Guardian or Personal Representative

Date

Signature of Therapist

Date

Therapist Name & Contact Info:

CONFIDENTIALITY NOTICE from Kelley Counseling HIPAA Privacy Notification: Anyone receiving this information must also treat this medical information as confidential and needs to follow HIPAA and CFR42 guidelines.